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No. 04-___

IN THE

Supreme Court of the United States

MERCK & CO., INC.; UNUM LIFE INSURANCE COMPANY OF AMERICA; AND MERCK & CO., INC. LONG TERM DISABILITY PLAN FOR UNION EMPLOYEES,

Petitioners,

v.

CELESLIE EPPS-MALLOY,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether an ERISA plan fiduciary exercising discretionary authority to determine claims for disability benefits commits a "procedural irregularity" that results in decreased judicial deference to the fiduciary's benefits decision, merely because the fiduciary requests an independent medical examination in reviewing a claim that calls for medical judgment.

PARTIES TO THE PROCEEDING

Michaleen Kosiba and Celeslie Epps-Malloy were the plaintiffs in the district court. Ms. Epps-Malloy was the appellant in the Third Circuit. Ms. Kosiba settled her case in the district court and did not participate on appeal. Merck & Co., Inc., UNUM Life Insurance Company of America, and Merck & Co., Inc. Long Term Disability Plan for Union Employees were the defendants in the district court and the appellees in the Third Circuit.

RULE 29.6 DISCLOSURE STATEMENT

Merck & Co., Inc. is a publicly-traded corporation. UNUM Life Insurance Company of America is a wholly-owned indirect subsidiary of UnumProvident Corporation, which is a publicly-traded corporation. Merck & Co., Inc. Long Term Disability Plan for Union Employees is an employee welfare benefit plan.

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PETITION FOR A WRIT OF CERTIORARI

Petitioners Merck & Co., Inc. ("Merck"), UNUM Life Insurance Company of America ("UNUM"), and Merck & Co., Inc. Long Term Disability Plan for Union Employees (the "Plan") respectfully petition this Court for a writ of certiorari to review the decision of the United States Court of Appeals for the Third Circuit, which involves an important question under the Employee Retirement Income Security Act of 1974 ("ERISA"): The impact of a plan fiduciary's request for an independent medical evaluation ("IME") on the arbitrary and capricious standard of review that otherwise would apply to the fiduciary's denial of benefits under *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

The Third Circuit's decision merits this Court's review. The court of appeals held that a request for an IME as part of the review of a disability benefits claim under an ERISA-governed plan constitutes a "procedural irregularity" that implies a conflict of interest and reduces a court's deference to the plan fiduciary's benefits determination. The decision rests on the assumption that IMEs are intrinsically unreliable or unfair—an assumption that this Court rejected in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003). The Third Circuit's decision also conflicts with decisions in other circuits that have held that the use of an IME is evidence of reasonableness and fairness in the evaluation of an ERISA claim and, conversely, that a failure to obtain an IME under some circumstances is evidence of unreasonableness and unfairness. This is the first circuit court decision to condemn and penalize a fiduciary for requesting an IME. It places administrators in the position of being "damned if they do and damned if they don't" when they consider obtaining IMEs as part of their review of claims involving medical issues. Compounding the dilemma for fiduciaries is the fact that current Department of Labor ("DOL") regulations governing ERISA claim procedures *require* benefit plans to consult with qualified health care professionals when considering claims that involve medical judgment. Certainly, a fiduciary's compliance with DOL regulations by requesting an IME cannot constitute a "procedural irregularity."

Petitioners respectfully request the Court to review the Third Circuit's decision and to restore uniformity in the lower courts by holding that a fiduciary's reasonable request for an IME during the ERISA claim review process is not a "procedural irregularity" that supports an inference of a conflict of interest. This holding will give claim fiduciaries exercising discretionary authority the necessary latitude to decide when to use IMEs in order to comply with DOL claim procedure regulations. It will further enable those fiduciaries to fully and fairly review benefit claims, and to protect

plan assets from dissipation due to the approval of meritless claims.

OPINIONS BELOW

The district court's unpublished memorandum opinion, dated December 27, 2001, is reproduced in the Appendix to this petition ("App.") at 21a. The opinion of the Third Circuit is reported at 384 F.3d 58 and reproduced at App. 1a.

JURISDICTION

The judgment of the Third Circuit was entered on September 13, 2004. The Third Circuit denied a timely petition for rehearing and rehearing en banc on October 27, 2004. Petitioners invoke the jurisdiction of this Court under 28 U.S.C. § 1254(1) (2000).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 404(a)(1) of ERISA, 29 U.S.C. § 1104(a)(1) (2000), defines an administrator's basic fiduciary duties under the Act. Section 503(2), *id.* § 1133(2), requires every plan to afford participants a reasonable opportunity to appeal adverse benefit determinations to the plan fiduciary. The DOL enacted 29 C.F.R. § 2560.503-1 to implement Section 503(2). In 1997, when Ms. Epps-Malloy internally appealed from UNUM's denial of her claim, that regulation required every plan to establish a procedure by which a claimant could obtain a full and fair review of a claim denial. 29 C.F.R. § 2560.503-1(g) (1997). The current regulation further provides that where a determination of a claim for benefits requires medical judgment, the fiduciary, in deciding an administrative appeal, must consult with a qualified health care professional in the relevant field of medicine. 29 C.F.R. § 2560.503-1(h)(3)(iii) (2004), *incorporated in* 29 C.F.R.

§ 2560.503-1(h)(4) (2004). These statutory and regulatory provisions are set forth at App. 65a through 68a.

STATEMENT OF THE CASE

Factual Background. Ms. Epps-Malloy, who worked in a Merck cafeteria, was a participant in the Plan, for which Merck acts as the plan administrator and UNUM acts as the claims administrator. The Plan gives Merck discretionary authority to construe the terms and provisions of the Plan and to determine claims. Merck delegated that authority to UNUM, as the Plan permitted. Court of Appeals Appendix ("C.A. App.") 368-69, 403. The Plan provides benefits for participants who are disabled from performing their regular jobs for Merck for the first 24 months of long-term disability, and continuing benefits thereafter for those participants who are disabled from any gainful occupation for which the employee is reasonably qualified. The Plan provides for the termination of benefits when the participant is no longer totally disabled.

Regarding IMEs, the Plan states:

> The Administrator, as often as may be reasonably required, shall have the right to require any employee receiving a benefit under this Plan to undergo a medical examination by a physician or physicians designated by the Administrator and to provide other evidence of continuing disability . . . .
>
> [T]he Plan Administrator and Claims Administrator shall have the right and opportunity, at their own expense, to examine any person when and so often as they may reasonably require during the pendency of a claim for benefits hereunder.

Id. at 371, 372.

In 1991, after a workplace injury, Ms. Epps-Malloy did not return to work. Thereafter, she was approved for long-term

disability benefits, retroactive to November 1991, subject to periodic reevaluations to determine her continued eligibility.

In 1996, after Ms. Epps-Malloy had been paid short- and long-term benefits for five years, UNUM requested updated medical information from her then-current treating physicians in order to review her disability status. Based on the perceived inadequacy of the medical evidence—in particular, her doctor's reliance exclusively on a test conducted over six years earlier to support his diagnosis of sarcoidosis[1]—UNUM concluded that Ms. Epps-Malloy was no longer totally disabled. Therefore, Merck ceased paying benefits in December 1996.

In January 1997, Ms. Epps-Malloy appealed the termination and submitted a treatment note from a physician whom she had consulted for the first time a week earlier, after receiving UNUM's termination letter. While the new doctor reported Ms. Epps-Malloy's subjective complaints regarding "respiratory distress" and concluded that she had "severe sarcoidosis" and could not return to gainful employment, his treatment note failed to reflect objective testing to confirm her subjective complaints and to support the sarcoidosis diagnosis. C.A. 467. After a UNUM staff nurse questioned the validity of the conclusions reached in the January 1997 treatment note, UNUM requested Ms. Epps-Malloy to appear for an IME by a pulmonology specialist.

Based on the results of objective tests, the IME doctor "ha[d] a difficult time ascribing sarcoidosis as a cause of her

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[1] Sarcoidosis is a disease that causes inflammation of the body's tissues. According to the United States Department of Health and Human Services, it "usually is a mild condition and does not result in lasting harm to tissues," and "even those who need treatment can usually lead a normal life." *Facts About Sarcoidosis*, National Institute of Health Publication No. 02-5060 (April 2003), *available at* http://www.nhlbi.nih.gov/health/public/lung/other/sarcoidosis/sarcoid.pdf.

symptomatology." Rather, in his view, Ms. Epps-Malloy "appear[ed] to be somewhat emotional," and he could "not reliably exclude her malingering behavior." Ultimately, he concluded "based on her pulmonary function tests and arterial blood gas information, that her present diagnosis [of sarcoidosis] is incompatible with her clinical presentation." *Id.* at 481.[2] Relying on the IME, UNUM adhered to its decision to terminate benefits.

Proceedings Below. In challenging the termination of benefits, Ms. Epps-Malloy invoked the jurisdiction of the district court under 29 U.S.C. §§ 1132(a)(1)(B), 1132(e), and 1132(f) (2000), and under 28 U.S.C. § 1331 (2000). In lieu of a bench trial, the district court made findings of fact and conclusions of law based upon the stipulated administrative record, the parties' trial briefs, and oral argument.

The district court applied an arbitrary and capricious standard of review to UNUM's termination decision because the Plan confers discretionary authority. App. 40a-41a, 47a-48a. The court rejected the argument that Merck had an inherent conflict due to its dual roles as plan administrator and funding source and, therefore, that a heightened standard of review applied. *Id.* at 41a-47a. Relying principally on the 1997 IME, the court found substantial evidence in support of UNUM's determination that Ms. Epps-Malloy was no longer totally disabled, *id.* at 51a; therefore, it held that the termination decision was not arbitrary and capricious, and it ordered dismissal of Ms. Epps-Malloy's claims. *Id.* at 57a, 63a-64a.

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[2] Some of Ms. Epps-Malloy's earlier medical reports included diagnoses of fibromyalgia in addition to sarcoidosis. The district court did not address the evidence related to the fibromyalgia diagnosis, and, therefore, the Third Circuit remanded for a new trial on that issue. App. 16a-18a. Petitioners do not seek this Court's review of that particular ruling of the Third Circuit.

The Third Circuit reversed on the basis that the district court had erred in applying an unmodified arbitrary and capricious standard of review. Initially, after a lengthy discussion of the possibility of a conflict of interest based on Merck's roles as both plan administrator and funding source, the court concluded that the record was insufficient to establish a conflict and to "impose a heightened standard of review on this ground." *Id.* at 13a-14a. However, the Third Circuit stated that "demonstrated procedural irregularity, bias, or unfairness in the review of the claimant's application for benefits" is an independent "cause for heightened review." *Id.* at 12a-13a. Acknowledging that the court never before had reduced deference based exclusively on the presence of a procedural irregularity, *id.* at 13a, the panel did so in this case—based solely on UNUM's and Merck's request that Ms. Epps-Malloy submit to an IME. *Id.* at 14a-16a. The court did not find any procedural irregularity in the *performance* of the IME. It held only that the request itself was improper. *Id.* at 15a.

Because the Third Circuit held that the district court had applied too deferential a standard of review, it remanded for a new trial under a "moderately heightened arbitrary and capricious standard," without reaching the merits of Ms. Epps-Malloy's claim. *Id.* at 16a. The court denied Petitioners' petition for rehearing and rehearing en banc. App. 19a.

REASONS FOR GRANTING THE WRIT

In *Firestone*, this Court held that courts generally should review a denial of benefits for abuse of discretion when the controlling plan vests the fiduciary with "discretionary authority to determine eligibility for benefits or to construe the terms of the plan." 489 U.S. at 115. The Court further noted, however: "Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a

'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting Restatement (Second) of Trusts § 187, comment d (1959)). That single sentence, which is all that the Court said on the subject in *Firestone*, has yielded enormous disagreement among the courts of appeals over what type of conflict reduces the deference otherwise due to ERISA benefit determinations by fiduciaries with discretionary authority.[3]

Some circuits have held that "procedural irregularities" in the benefits claim process constitute evidence of such a conflict and may result in less deference to a fiduciary's decision under *Firestone*, at least where the irregularity "caused a serious breach of the plan administrator's fiduciary duty" and "'has some connection to the substantive decision reached.'" *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160-61 (8th Cir. 1998) (citation omitted). In this case, the Third Circuit took this principle to a new level by condemning UNUM for requesting an *independent* medical examination as part of its reevaluation of Ms. Epps-Malloy's claim for continued long-term disability benefits. Without questioning the bona fides of the IME itself, the court deemed the mere *request* for the independent examination a "procedural irregularity" that required departure from the arbitrary and capricious standard of review.

The Third Circuit's decision adds to the confusion that already exists among the circuit courts as to what circumstances will alter what would otherwise be a deferential standard of review. Fiduciaries routinely use IMEs, particularly in evaluating health and disability claims. Under the current regime, the same administrator making the same

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[3] In a separate petition filed concurrently with the instant petition, UNUM is requesting the Court to grant certiorari review of the Tenth Circuit's decision in *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997 (10th Cir. 2004), in order to clarify this aspect of *Firestone*.

claim decision under the same employee benefit plan can be subject to different review standards, and potentially different results, depending on where a suit for benefits is filed. In every other circuit that has addressed the issue, reliance on an IME is evidence that a conflict of interest does not exist or that a denial was not arbitrary and capricious, while in the Third Circuit, the same reliance will heighten review of a benefits denial, as if a conflict does exist. Given ERISA's rather generous venue provisions, one can expect disappointed claimants to forum-shop in order to seek the body of law that gives them the best chance of prevailing. But fiduciaries of benefit plans should not be forced to make claim determinations, including decisions about whether to request IMEs, in this fractured environment.

One purpose of ERISA was to encourage employers to adopt employee disability plans, which are not required by law but which greatly benefit disabled employees and society as a whole. The Third Circuit's ruling, which permits a fiduciary to adequately investigate some claims only if it foregoes the full degree of discretion that otherwise would attach to its claim decisions, will increase employers' costs and will discourage the provision of health welfare benefits, contrary to Congress' goal of increased adoption of such plans. Petitioners respectfully request this Court to grant review and resolve the circuit split by holding that a request for an IME is not evidence of a conflict of interest and does not dilute the deference otherwise owed to a fiduciary's benefits determination under *Firestone*.

I. THE THIRD CIRCUIT'S DECISION, WHICH PRESUMES BIAS FROM A FIDUCIARY'S REQUEST FOR AN IME AND THUS GIVES REDUCED DEFERENCE TO A DENIAL OF BENEFITS, CONFLICTS WITH DECISIONS OF THIS COURT AND OTHER FEDERAL COURTS OF APPEALS.

An IME is just that—an independent evaluation of a claimant's medical condition. In the context of a claim for disability benefits, an IME is often used, as in this case, to help the fiduciary determine whether the claimant meets the plan's definition of "disability." An IME may be employed because the submitted medical support for the claim is controverted, ambiguous, or incomplete—as the Third Circuit conceded it was in this case, App. 15a. A fiduciary also may request an IME where the medical evidence, though consistent, warrants additional consideration, including by a specialist. *See, e.g.*, *Stratton v. E.I. DuPont de Nemours & Co.*, 363 F.3d 250, 257-58 (3d Cir. 2004) (affirming denial of health benefits where treating physician's report fully supported claim, but IME reached different conclusion); *Donato v. Metro. Life Ins. Co.*, 19 F.3d 375, 380 (7th Cir. 1994) (same).[4]

In *Black & Decker*, the Court held that fiduciaries may rely on the views of "consultants retained by a plan," including on IMEs, in lieu of deferring to treating doctors' opinions on questions of disability. 538 U.S. at 832. The Court made

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[4] Fiduciaries administering ERISA-governed medical plans also often rely on IMEs to evaluate benefits claims. For example, IMEs can be critical in determining whether particular treatments are experimental or medically necessary. *See, e.g.*, *Ortlieb v. United Healthcare Choice Plans*, 387 F.3d 778, 783-84 (8th Cir. 2004); *Barnett v. Kaiser Foundation Health Plan, Inc.*, 32 F.3d 413, 415-16 (9th Cir. 1994).

clear that there is nothing intrinsically unreliable or unfair about IMEs and, hence, no inherent impropriety in their use:

> [T]he assumption that the opinions of a treating physician warrant greater credit than the opinions of plan consultants may make scant sense when, for example, the relationship between the claimant and the treating physician has been of short duration, or when a specialist engaged by the plan has expertise the treating physician lacks.

Id.[5]

Even before *Black & Decker*, the courts of appeals had consistently recognized the benefits of IMEs in assessing health and disability benefit claims under ERISA. As well-stated by the First Circuit, "[a]nalyzing disability claims plainly requires expertise. It is, therefore, difficult to fault a plan administrator for seeking expert assistance (indeed, it probably would be easier to fault a plan administrator for not seeking such assistance)." *Leahy v. Raytheon Co.*, 315 F.3d 11, 16 (1st Cir. 2002). According to the Seventh Circuit, "[s]eeking independent expert advice is evidence of a thorough investigation," and, therefore, fiduciaries act appropriately when they make reasonable IME requests. *Hightshue v. AIG Life Ins. Co.*, 135 F.3d 1144, 1148 (7th Cir. 1998). Indeed, every other circuit that has considered the use of IMEs has concurred that they *add value* to, rather than detract from, an initial benefit determination and review on internal appeal. *See infra* at 18-20. *Cf.*, *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 383-84 (2002) (state laws that require second opinion before health insurers may deny coverage "ensure sound medical judgments").

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[5] Significantly, Ms. Epps-Malloy's relationship with Dr. McQueen, the physician whose report prompted the IME, had been "of short duration." *See* C.A. 467 (note reflecting only one examination of Epps-Malloy one week after UNUM terminated her benefits); *see also* App. 6a.

The DOL also has embraced IMEs as a means of ensuring fairness and accuracy in claims calling for medical judgments. Under a regulation adopted in 2001, the DOL now requires that under ERISA, "*in deciding an appeal* of any adverse benefit determination that is based in whole or in part on a medical judgment . . . *the appropriate named fiduciary shall consult with a health care professional* who has appropriate training and experience in the field of medicine involved in the medical judgment." 29 C.F.R. § 2650.503-1(h)(3)(iii) (2004), *incorporated in* 29 C.F.R. § 2650.503-1(h)(4) (2004) (emphasis added). The DOL adopted this regulation in order "to ensure full and fair review of benefit denials." *Aetna Health Inc. v. Davila*, 124 S. Ct. 2488, 2502 (2004); *see also* 65 Fed. Reg. 70246, 70252 (Nov. 21, 2000) (regulation adopted "new standards [including requirement of consultation with independent health care professional] for a full and fair appeal of an adverse benefit determination"); Dept. of Labor, Employee Benefits Security Administration, *Frequently Asked Questions About the Benefit Claims Procedure Regulation*, D-8 (Sept. 4, 2002) ("EBSA FAQS"), *available at* http://www.dol.gov/ebsa/FAQS/faq_claims_proc_reg.html ("This requirement of consultation is intended to ensure that the fiduciary deciding a claim involving medical issues is adequately informed as to those issues.").

There is no question that the DOL regulation contemplates the use of IMEs in assessing disability claims. The agency has confirmed that "[m]any plans, including group health and disability plans, require claimants to submit to examination by an expert or experts of the plan's choosing in connection with the plan's consideration of the claimant's claim," and that the only limitation on such IME requests is that they

must occur in time to conform to the time frames stated in the 2001 regulation. EBSA FAQS C-4; *see also id.* at D-8, D-9.[6]

The DOL is the agency delegated by Congress to enforce ERISA and, in particular, to enact regulations to govern fiduciaries' review of claims. *See* 29 U.S.C. § 1002(13) (2000) (defining "Secretary" as the Secretary of Labor); *id.* § 1133 (requiring plans to conform to "regulations of the Secretary" governing claims procedures). The DOL regulation, which recognizes that IMEs often will be necessary in order to ensure the "integrity of the decision making process," 63 Fed. Reg. 48390, 48401 (Sept. 3, 1998), is entitled to deference from the courts. *See Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844 (1984).

Consistent with the DOL regulations, and like virtually all ERISA-governed disability and health plans, the Plan expressly permitted UNUM and Merck to request Ms. Epps-Malloy to submit to an IME in order to evaluate whether her disability was continuing. *See supra* at 4. Absent that right, fiduciaries would be hostage to the views of claimants' treating physicians, a result that conflicts directly with *Black & Decker*.

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[6] Other federal agencies have confirmed the value of IMEs in evaluating disability claims. *See, e.g.*, 20 C.F.R. § 404.1593(c) (2004) ("A consultative examination may be purchased when [the Social Security Administration] need[s] additional evidence to determine whether or not [a claimant's] disability continues."); 32 C.F.R. § 536.8(b) (2004) (in cases against the Department of the Army "in which there is an allegation of temporary or permanent disability, the claimant should be examined by an independent physician"). Virtually all states include some form of IME requirement in their workers' compensation and disability compensation schemes. *See, e.g.*, Alaska Stat. § 23.30.095(e) (2004); Cal. Labor Code § 4616.4 (West 2004); Cal. Code Regs. tit. 22, § 2627(c)-1 (2004); Ga. Code Ann. § 34-9-310 (2004); N.H. Rev. Stat. Ann. § 281-A:38 (2004).

Beyond the regulatory support and contractual basis for the IME request in this case, an ERISA fiduciary has a duty to all beneficiaries to preserve plan assets—including by scrutinizing claims carefully and declining claims that do not qualify under the plan. That duty serves the "common interest" of beneficiaries and employers alike in ensuring "the financial integrity of the plan." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 142 n.9 (1985). "The common law of trusts recognizes the need to preserve assets to satisfy future, as well as present, claims and requires a trustee to take impartial account of the interests of all beneficiaries." *Varity Corp. v. Howe*, 516 U.S. 489, 514 (1996) (citation omitted). Under these guiding principles, "[a] company failing to conduct proper inquiries into claims for benefits breaches its duties to all claimants as a fiduciary of the benefit funds when it grants claims to unqualified claimants." *Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 589 (8th Cir. 1999) (citation omitted); *see also Woolsey v. Marion Labs., Inc.*, 934 F.2d 1452, 1458 (10th Cir. 1991) ("ERISA requires that the Plan be administered with an eye solely to the best interests of all the beneficiaries."); *de Nobel v. Vitro Corp.*, 885 F.2d 1180, 1191 (4th Cir. 1989) ("Fiduciaries are obligated to act not only in the best interests of beneficiaries, but with due regard for the preservation of trust assets."). A fiduciary frequently "act[s] prudently on behalf of all beneficiaries by not accepting at face value the medical evidence as submitted by [the claimant], but by conducting a further inquiry into her claims of disability." *Barnhart*, 179 F.3d at 589.[7] Indeed, benefits determinations are at the heart of the discretion committed to ERISA fiduciaries, who must balance the interests of present claimants against the interests of

[7] Of course, fiduciaries are not required to request IMEs in all cases. For example, an internal medical review might be sufficient to evaluate the claim or the claim might turn on a question of policy interpretation, not medical judgment.

future claimants who benefit from the denial of meritless claims.

A. The Third Circuit's Decision Conflicts with This Court's Decision in *Black & Decker*.

The Third Circuit purported not to condemn IMEs in the abstract, ruling instead only that "the circumstances under which Merck made th[e] request" for an IME in *this* case "necessarily raise an inference of bias." App. 14a. In fact, because none of the identified circumstances calls into question Merck's and UNUM's good faith in soliciting an IME from Ms. Epps-Malloy, the Third Circuit's supposedly narrow holding is actually sweeping in scope:

- The fact that Ms. Epps-Malloy's "physician's [sic] reports uniformly supported her contentions," App. at 15a, proves nothing about the legitimacy of the IME request. Reasonable IME requests are appropriate whenever the fiduciary believes that additional review by a doctor other than the claimant's treating physician or the fiduciary's in-house medical staff would assist in determining a claim, regardless of the uniformity of the treating physicians' reports. *See supra* at 10-11.
- Similarly, the timing of the IME—"not at the initial determination stage, but at the appeal stage," App. 15a—suggests no mischief. Under most ERISA plans, the "appeal stage" is a critical part of the claim consideration process, and fiduciaries encourage claimants to submit additional medical evidence. *See* Dept. of Labor, Employee Benefits Security Administration, *What You Should Know About Filing Your Health Benefits Claim*, *available at* http://www.dol.gov/ebsa/publications/ wyskfhbc.html (undated) ("When appealing a benefit denial, be sure to include any additional information or evidence supporting your claim . . . ."). As the Third Circuit acknowledged, in this case Ms. Epps-Malloy submitted "addi-

tional information" during the appeal, "including the name of her new treating physician." App. 6a. When a UNUM nurse questioned the sufficiency of that new medical information, UNUM and Merck requested an IME. That sequence of events cannot reasonably be read as suggesting impropriety.

- Finally, there was nothing nefarious about Merck's supposed "interven[tion]" into UNUM's claim review. App. 14a-15a. First, the only evidence of Merck's involvement is a brief reference to Merck's request for an IME in a single letter from UNUM. C.A. 478. More to the point, Merck had a right to make this request. The Plan expressly provided that Merck and UNUM "shall have the right and opportunity, at their own expense, to examine any person when and so often as they may reasonably require during the pendency of a claim for benefits hereunder." *Id.* at 372.[8]

Setting aside these benign circumstances, all that is left to support the Third Circuit's inference of procedural irregularity is the fact of the IME request itself. But that inference is unwarranted unless IMEs are intrinsically partisan. And that assumption—on which the Third Circuit's conclusion fundamentally rests—is wrong as a matter of fact, law, and policy.

The Third Circuit's decision makes precisely the sort of assumption that this Court held impermissible in *Black & Decker*—"that the opinions of a treating physician warrant greater credit than the opinions of plan consultants." 538 U.S. at 832. The court of appeals has done exactly what this Court has said that courts may not do—"impose on plan

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[8] At oral argument in the district court, the parties agreed that Merck requested an IME "to give Ms. Epps-Malloy another chance," C.A. 123, at a time when UNUM was "ready to discontinue her right then and there" based on its in-house nurse's review of the medical record. *Id.* at 121. In other words, Ms. Epps-Malloy did not share the adverse inference the Third Circuit drew from Merck's role in the claim review process.

administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." *Id.* at 834.

Significantly, the Third Circuit's decision condemns UNUM's request for an IME without identifying a single deficiency in the evaluation itself. There is no hint of bias by the physician whom UNUM retained, no suggestion that he was unqualified to assess Ms. Epps-Malloy's condition, no intimation that the IME was a tool of harassment, and no evidence that the conclusions reached were not medically valid and reliable.

Perhaps most disturbing, by increasing the judicial scrutiny imposed on UNUM's and Merck's discretionary benefits decisions, the Third Circuit has penalized Petitioners for nothing more than the exercise of their contractual right to request an IME, their legal duty to perform an appropriate medical review in administrative appeals, and their fiduciary duty to all participants to protect the Plan's assets by ensuring the validity of an individual's claim.

Although the Third Circuit says that it "trust[s] that courts will not penalize plan administrators for seeking independent medical examinations at appropriate stages of the claims determination process," App. 16a, that is indeed what the court of appeals' decision does. It compels fiduciaries to choose between "collect[ing] enough information to make a responsible claims determination" and "avoid[ing] requesting more information in the hopes of maintaining the most deferential standard of review." *Id.* But this is a Hobson's choice: Under the Third Circuit's decision, abuse of discretion standard of review mandated in *Firestone* for discretionary benefits decisions applies only if fiduciaries rubber-stamp the opinions of treating physicians in contravention of *Black & Decker* and the current DOL regulations, and only if they pay claims without regard to fairness and accuracy, in contravention of their duties to all participants.

B. The Third Circuit's Decision Conflicts with Decisions in Other Circuits.

Among the courts of appeals, the Third Circuit stands alone in inferring procedural bias from a request for an IME. The First Circuit has specifically refused to "fault a plan administrator for seeking expert assistance," *Leahy*, 315 F.3d at 16, and therefore it declined to heighten the standard of review, based exclusively on an administrator's use of IMEs:

> We are aware of no case holding that a plan administrator operates under a conflict of interest simply by securing independent medical advice to aid in the evaluation process. Nor do we view this as an accident: common sense dictates that retaining outside physicians to assist in evaluating disability claims, without more, does not constitute a conflict of interest.

Id.

Exercising similar logic, other courts of appeals have held that (a) a fiduciary's reliance on an IME neutralizes or, at least, mitigates an administrator's structural conflict, or conversely, (b) a failure to obtain an IME evidences a bias that may decrease judicial deference. *E.g.*, *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1015 (10th Cir. 2004) ("Where, as here, a conflict of interest may impede the plan administrator's impartiality, the administrator best promotes the purposes of ERISA by obtaining an independent evaluation."); *Woo*, 144 F.3d at 1161 (applying less deferential review where "Hartford denied Woo's claim without seeking any independent medical review"); *Hightshue*, 135 F.3d at 1148 ("[P]rovided that the fiduciary has investigated the expert's qualifications, has provided the expert with complete and accurate information, and determined that reliance on the expert's advice is reasonably justified under the circumstances, the fiduciary's decision will be respected, despite the conflict of interest."); *Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 234 (4th Cir. 1997) ("MetLife's [inherent] conflict of

interest . . . was greatly mitigated by its substantial reliance on the evaluations of the independent Roundtable"); *Donato*, 19 F.3d at 380 n.3 (resort to two IMEs vitiated inherent conflict); *cf.*, *Morgan v. UNUM Life Ins. Co. of Am.*, 346 F.3d 1173, 1177 (8th Cir. 2003) ("In some circumstances, the administrator's use of an in-house physician rather than a[n outside] specialist to review a disability claim involving an uncommon disease can be a serious procedural irregularity affecting the administrator's decision.") (citations omitted).

The courts of appeals also have uniformly cited a fiduciary's use of an IME as evidence of reasonableness and fairness in the evaluation of claims—and, conversely, have identified the failure to obtain an IME as evidence of unreasonableness and unfairness. *See, e.g.*, *Williams v. BellSouth Telecomms., Inc.*, 373 F.3d 1132, 1139 (11th Cir. 2004) (affirming denial of benefits under either *de novo* or arbitrary and capricious standard of review, where administrator "thoroughly reviewed medical evidence concerning Williams's condition, including that of an IME"); *House v. Paul Revere Life Ins. Co.*, 241 F.3d 1045, 1048 (8th Cir. 2001) (insurer "was entitled to require House to submit to an [IME] and . . . would have been entitled to discount [the treating doctor's] opinion entirely in favor of a contrary opinion produced by the independent examiner"); *Sweatman v. Commercial Union Ins. Co.*, 39 F.3d 594, 601-03 (5th Cir. 1994) (no abuse of discretion where MetLife, *inter alia*, "contracted independent medical consultants to evaluate [plaintiff's treating physician's] records and determine whether they supported her physical limitations"); *Madden v. ITT Long Term Disability Plan for Salaried Employees*, 914 F.2d 1279, 1286 (9th Cir. 1990) (evidence, including fiduciary's reliance on "an independent outside service, to assess Madden's benefit claim," established reasonableness and impartiality of its decision); *cf.*, *Todd v. Aetna Health Plans*, 31 Fed. Appx. 13 [2002 WL 257364 at *1] (2d Cir. 2002) (though finding no abuse of discretion in Aetna's

failure to seek an IME, characterizing its conduct as "highly questionable in light of the indications of Todd's disability").[9]

In short, the conflict between the Third Circuit's decision and the law of every other circuit that has reached the IME issue could not be more pronounced.[10]

II. THE IMPACT OF AN IME REQUEST ON THE ERISA STANDARD OF REVIEW IS A RECURRING ISSUE OF NATIONAL IMPORTANCE TO CLAIMANTS, EMPLOYERS, AND FIDUCIARIES.

The interest in uniformity. In enacting ERISA, Congress sought to foster a "uniformity of decision" to "help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws." S. Rep. No. 93-127, at 29 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4838, 4865. Congress wanted to "ensure that plans and plan sponsors would be subject to a uniform body of benefits law" so as to "minimize the administrative and financial burden of complying with conflicting direc-

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[9] Indeed, the Third Circuit's decision conflicts even with that court's own precedent. For example, in *Abnathya v. Hoffman-La Roche, Inc.*, 2 F.3d 40 (3d Cir. 1993), the court relied largely on two IMEs for its holding that the denial of benefits was not arbitrary and capricious. *Id.* at 47-48; *see also Stratton*, 363 F.3d at 257 (affirming denial where administrators, *inter alia*, had independent physician "review the information submitted [by plaintiff's treating physician] before finally denying Stratton's request").

[10] The Third Circuit's analysis conflicts with decisions of other courts in another, related respect. Those courts that have deemed a procedural irregularity to be a basis for reducing deference to a fiduciary's benefits determination have required "material, probative evidence, beyond the mere fact of the apparent irregularity, tending to show that the administrator breached his fiduciary obligation." *Buttram v. Central States, S.E. & S.W. Areas Health & Welfare Fund*, 76 F.3d 896, 900 (8th Cir. 1996). The Third Circuit's decision, however, mandates no such inquiry.

tives," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)—"burdens ultimately borne by the [plan's] beneficiaries," *Egelhoff v. Egelhoff*, 532 U.S. 141, 150 (2001). However, "[u]niformity is impossible" if different courts subject plans to "different legal obligations." *Egelhoff*, 532 U.S. at 148. *See also Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) ("uniform administrative scheme" intended under ERISA would be "difficult to achieve" if a plan were required "to process claims in a certain way in some States but not in others").[11]

The Third Circuit's decision defeats Congress' goal of uniformity. By equating an IME with procedural bias, the Third Circuit creates a difficult practical problem for fiduciaries. Under the cases of almost every other circuit, administrators facing medical judgments have either an incentive or obligation to avail themselves of IMEs. In the Third Circuit alone, they do so at their peril—at the risk of losing the deference that the plan documents, the law of trusts, and *Firestone* otherwise would compel.

The decision below leaves ERISA plan fiduciaries in a quandary as to when they may, should, or must rely on IMEs. Administrators of plans governing employees in multiple federal circuits, as under the Plan in this case, must either establish diverse claim review protocols based on geography alone, or accept heightened review based solely on their appropriate resort to independent analysis of claims raising difficult questions of medical judgment.

The interest in uniformity on this issue is great. Fiduciaries should not be forced to operate under two mutually-exclusive claim processing protocols—one of which is based not on

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[11] The cited cases all considered the need for uniform law in the context of preemption under ERISA of varying state laws. The underlying interest in uniformity, however, applies equally to the federal courts' application of the Act.

"best practices," but rather, on the views of a single federal court. The burden is particularly onerous on national employers like Merck, which review claims by employees in every federal circuit.

Absent clarification by this Court, the Third Circuit's holding will be costly for plans, whose assets will be drained through the payment of invalid claims that will not be tested through IMEs, where appropriate. It will lead to forum-shopping under ERISA's liberal venue provision, which permits the filing of suit to recover benefits "in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found." 29 U.S.C. § 1132(e)(2) (2000).[12] And it will be confusing and inequitable to participants.

The interest in accurate and fair claims procedures. A fundamental purpose of ERISA is to ensure that claim determinations are made fairly and accurately. Toward that end, the Act requires plans to provide for explanations of claim denials and for "full and fair review" of denials. 29 U.S.C. § 1133 (2000). ERISA also creates a civil cause of action "to recover benefits due" to plan participants. *Id.* § 1132(a)(1)(B).

The Third Circuit's decision will frustrate the paramount public interest in fair and accurate claim determinations by penalizing fiduciaries for using an often-essential resource for evaluating claims – the IME. DOL claim procedures, enacted for the purpose of enforcing ERISA's fairness requirement, recognize the need for claim administrators to obtain advice

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[12] The courts have construed the "may be found" language as providing for venue in any district in which the defendant has minimum contacts sufficient to establish personal jurisdiction. *See I.A.M. Nat'l Pension Fund, Benefit Plan A v. Wakefield Indus., Inc.*, 699 F.2d 1254, 1257-58 (D.C. Cir. 1983); *Varsic v. United States Dist. Court for the Central Dist. of Cal.*, 607 F.2d 245, 248 (9th Cir. 1979).

from medical professionals when benefits claims involve issues of medical judgment. The Third Circuit's decision fundamentally interferes with fiduciaries' obligations under these regulations. The current DOL regulations apply to claims filed on or after January 1, 2002, after termination of Ms. Epps-Malloy's benefits. However, the regulations confirm that in deciding appeals, fiduciaries *must* evaluate claims involving medical issues by consulting with medical experts. The only choice is whether to consult with an in-house medical professional, where such an individual is available, or to consult with an IME doctor. If UNUM had limited its analysis to review by an in-house physician, the Third Circuit presumably would not have questioned its fairness. Indeed, UNUM did ask a staff nurse to review the file and the Third Circuit voiced no criticism of that decision. Certainly, UNUM's decision to obtain the independent views of an outside specialist rather than relying solely on its employees' views should not be held against the company.

The interest in encouraging ERISA plans. "Employers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995). Well aware of this freedom, Congress cautioned that plans should not be so heavily burdened by regulation that "employers respond . . . by decreasing benefits under existing plans or slowing the rate of formation of new plans." H.R. Rep. No. 93-807, at 15 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4670, 4682. Yet, the Third Circuit's punishment of fiduciaries for availing themselves of IMEs runs counter to "the public interest in encouraging the formation of employee benefit plans." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987).

Specifically, by making IMEs unavailable unless the plan foregoes deferential review of its claim decisions, the Third Circuit's decision will lead to the approval of some non-

meritorous claims that would not otherwise be approved, and *should not* be approved. The approval of invalid claims, in turn, will render plans more costly. *See* 65 Fed. Reg. at 70260 ("limiting access to inappropriate care" enhances insurers' "abilities to effectively control costs"). The inevitable result is that some employers will either reduce the coverage provided under their plans or will decline to offer those benefits at all.

Moreover, the Third Circuit's unique condemnation of IMEs requires fiduciaries administering national plans to follow different procedures for claims that might end up in litigation in that circuit—at least, if they wish to preserve the arbitrary and capricious standard of review that would otherwise apply to their determinations. But "the administrative and financial burden of complying with conflicting directives," *Ingersoll-Rand*, 489 U.S. at 142, can be expected to encourage employers to cut back on ERISA-governed plans, or to discourage employers from adopting those plans in the first instance. "A patchwork scheme of regulation . . . introduce[s] considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax*, 482 U.S. at 11; *see also Varity*, 516 U.S. at 497 (recognizing Congress' "desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place") (citations omitted).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted, and the judgment of the Third Circuit reversed.

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